

[illegible]

Medicaid Management Information System – POTO-20006-R-0077

Amendment No. 3 - Attachment A - Questions and Answers

1. Delete No. 14 in its entirety and substitute the following:

14. Given the scope of the District's RFP and the level of detail required for bidders' responses, especially with regard to RFP Sections L.8.2, L.8.3, and L.8.4, a bidder's proposal response could be between 1500 and 2000 pages. Any vendor responding to an RFP of this magnitude and complexity will need the additional time to prepare a fully responsive proposal. In this regard, will the District provide an extension for the proposal due date until September 29, 2006?

The District has modified the RFP to provide an extension to September 25, 2006. The modified RFP is posted on the DC OCP website.

2. Delete No. 15 in its entirety and substitute the following:

15. The RFP states the operational start date is February 28, 2008. Pricing Schedule B.4.1 defines the implementation period as 18 months. Given the complexity of modifying and implementing an MMIS, is it the District's intention to preserve the entire implementation period if delays occur in awarding and signing the new contract?

It is the District's intent to begin operation with the supplied and modified MMIS on March 1, 2009. This is the correct Operations Start Date.

3. Delete No. 16 in its entirety and substitute the following:

16. The most recent procurements for the modification and implementation of an MMIS have allowed a minimum of 22-24 months for the design, development, testing and implementation of the system. Will the District extend the implementation period to 22 months?

Yes.

4. Delete No. 120 in its entirety and substitute the following:

120. C.7.1.3

Do all enhancements have to be operational and implemented on the go live date, February 28, 2008?

All enhancements have to be operational and implemented on the go live date of March 1, 2009.

5. Delete No. 113 in its entirety and substitute the following:

In our experience with Drug Rebate programs, States do not retain ownership of the Drug Rebate System as these systems are proprietary. Rather, the State owns the data. Please confirm that it is the District's intention to own the data, not the system.

As stated at the pre-bidder's conference, it is the District's intent to own the MMIS system with full functionality and the associated data. The Drug Rebate programs should be part and parcel to the MMIS functions.

6. Delete No. 151 in its entirety and substitute the following:

Industry standards use Arial 10 point font (which is very close in size to Times New Roman 12 pt font) for exhibits, graphics, and tables and is easily readable. Will the District please reconsider its response and allow Offerors to use Arial 10 point font for exhibits, graphics, and tables as long as readability is not compromised? Please see an example of a graphic using a 10 point font versus a 12 point font on the next two pages.

Per the RFP, proposals shall be typewritten in 12 point font size on 8.5" by 11" bond paper. Exhibits, graphics, and tables will be exempt and offerors can use Arial 10 point font for exhibits, graphics, and tables.

Amendment No. 3 - Attachment B - Revisions to Solicitation

1. Delete No. 62 in its entirety and substitute the following:
 62. Delete Section L.8.4.4, L.8.4.4.1, L.8.4.4.2 and L.8.4.5 in their entirety and substitute the following:
 - L.8.4.4. The Contractor must specify a firm fixed unit price to perform all Contractor services for the claims volume indicated in schedule B.4.2 – B.4.6 for each of the contract period of operations.
 - L.8.4.4.1 All costs (machine time, personnel, and documentation support) for modification and maintenance support, as well as operations, are to be included in this fixed price offer for each year. offerors must not include costs for postage since these are reimbursement basis costs as specified in Subsection H.30. Any anticipated costs for the Turnover task should be included in Pricing Schedule B.4.6 for the last contract period of operations.
 - L.8.4.4.2 The District is requiring offers for optional resource personnel including one (1) health care data analyst and one (1) analyst/programmer. Offerors are instructed to complete Section B.4.7 for these optional resource personnel. Amounts offered for the optional resource personnel will be included in the total price on Pricing Section B.4. The District reserves the right to utilize all or any of the optional resource personnel during any period of the contract. Utilizing this resource levels will require a contract modification.
 - L.8.4.5 Pricing Schedule B.4.7 must reflect the monthly rates for optional resource personnel described in subsection C.4.6, Minimum Qualifications for Optional Resource Personnel. The monthly rate specified on Schedule B.4.7 should be for one full time person working 160 hours per month. Documentation supporting Contractor preferences, as

described in Section M.3, should also be submitted if the Contractor qualifies.

2. Delete No. 63 in its entirety.
3. Delete No. 68 in its entirety and substitute the following:
 68. Delete Section H.37.6.1 and H.37.6.2 in their entirety and substitute the following:
 - H.37.6.1 The District intends to have the planned District of Columbia MMIS fully operational on March 1, 2009 as set forth in Section C.1.11.1 (5) of this RFP. On or before March 1, 2009, the Contractor shall provide a fully operational system that can begin processing correctly all claim types, claims adjustments, and other financial transactions; maintaining all system files; producing all required reports; and performing all other Contractor responsibilities specified in as set forth in Section C.7.20 of this RFP for the new MMIS. The Contractor shall provide a system with all enhancements approved by the District.
 - H.37.6.2 Compliance with the March 1, 2009, date is critical to the District's interest. Therefore, the Contractor shall be liable for resulting damages stated in Section H.37.7 if this date is not met. The District shall determine the Contractor's capability to meet this date following the conclusion of the operational readiness test as set forth in Section C.7.20 of this RFP.

Attachment B - Revisions to Solicitation - New Changes

1. Insert the following to Section C.1.12 after “CCMS”:

Certifiable MMIS - an MMIS system currently in use another state that has been identified by an independent third party MMIS expert as meeting the criteria of CMS certification and accreditation.

2. Delete Section B.1.1 in its entirety and substitute the following:

B.1.1 Provide, Enhance and Implement a federally owned and certified or certifiable Medicaid Management Information System (MMIS) as set forth in Section C.3 through C.7 of this Request for Proposal (RFP). The Contractor shall enhance the MMIS by using current information technology to enable the efficient and responsive operation of the District’s Medicaid Program as described in Section C.1.

3. Delete Section C.1.2 in its entirety and substitute the following:

C.1.2 The District of Columbia requires the enhancement, implementation and operation of a certified or certifiable Medicaid Management Information System (MMIS) to perform the functions described in this RFP and those that will be defined during requirements analysis phase as described in Section C.7.1 Design Subtask.

4. Delete Section C.1.3 in its entirety and substitute the following:

C.1.3 The solution the Contractor provides shall meet all requirements described in this solicitation, shall meet all HIPAA regulatory requirements, and must be certified by Center for Medicare and Medicaid Services (CMS) or be certifiable under the Federal criteria for an MMIS. The solution shall have the following characteristics:

5. Delete Section C.1.5 and substitute the following:

C.1.5 The District is seeking a Contractor to provide an existing CMS-certified or certifiable MMIS system with enhancements as specified by the District.

6. Delete Section C.2.1 in its entirety and substitute the following:

C.2.1 The District of Columbia uses the services of a Contractor to operate and maintain the District’s certified or certifiable MMIS. The re-procurement of the services of a claims processing Contractor will support the District’s

\$1.3 billion Medicaid program.

7. Delete Section C.2.2 in its entirety and substitute the following:

C.2.2 The Contractor selected by the District through the procurement process shall be required to provide to the District a system used in a currently operational and CMS certified or certifiable MMIS and implement certain system enhancements and improvements prior to assuming operational responsibilities.

8. Delete Section C.3.10.1, sub-paragraph (g) in its entirety and substitute the following:

(g) Current ICD, Revenue, DRG, CPT, and HCPCS code tables;

9. Delete Section C.5.9.1.1.1 in its entirety and substitute the following:

C.5.9.1.1.1 The Contractor shall provide all services associated with Production Operations Support including the following activities:

- (a) Batch cycle scheduling specifications, including job turn-around time monitoring and problem resolution;
- (b) Database administration;
- (c) Problem identification and resolution;
- (d) Software release and emergency implementation; Change Management and Version Management;
- (e) System resource forecasting;
- (f) Response time monitoring and problem resolution;
- (g) Software migration;
- (h) Contractor's LAN support and administration;
- (i) MMIS security implementation and monitoring;
- (j) Daily, weekly, and monthly production status reporting;
- (k) Mainframe liaison support with ISD;
- (l) Weekly or monthly encounter processing and problem resolution; and
- (m) All other activities required meeting the requirements and the performance specifications of the contract.

10. Delete Section C.6 sub-paragraph 8 in its entirety and substitute the following:

8. Claims and Encounter Pricing;

11. Delete Section C.6 sub-paragraph 10 in its entirety and substitute the following:

10. Claims and Encounter Operations Management;

12. Delete Section C.6.1.7.1 sub-paragraph (f) in its entirety and substitute the following:

(f) Encounter data in the form of "shadow claims" in HIPAA standard COB format from MCOs,

13. Delete Section C.6.1.7.2.26 in its entirety and substitute the following:

C.6.1.7.2.26 Provide the ability to receive, process (edit and price), retain MCO payment, and report on encounter data in the form of shadow claims for managed care recipient enrollees.

14. Delete Section C.6.1.7.2.37 in its entirety and substitute the following:

C.6.1.7.2.37 Generate electronic encounter data remittance advices that include the HIPAA transaction and necessary MCO reports.

15. Delete Section C.6.1.7.2.38 in its entirety and substitute the following:

C.6.1.7.2.38 Provide for web-enabled communication for delivery capitation and encounter 997s and RAs to managed care plans. The web-enabled Managed Care Roster and Remittance Advice delivery system must send HIPAA compliant EDI formats and meet District security, confidentiality and privacy requirements and HIPAA and other federal security, confidentiality and privacy requirements.

16. Delete Section C.6.1.7.3.4 in its entirety and substitute the following:

C.6.1.7.3.4 The following types of reports shall minimally be available:

- (a) All federal and state required reports including those needed to support the 1115A waiver;
- (b) Amount and type of services provided by capitated plans to enrolled recipients, as reported on encounter forms;
- (c) Numbers of services paid outside each plan;
- (d) Managed care enrollees by source of their enrollment;
- (e) Total medical assistance expenditures for managed care recipients versus non managed care expenditures by program and eligibility category;

- (f) Identification of recipients who are eligible but not enrolled in managed care and those recipients who are not eligible to be enrolled but have been assigned to a MCO;
- (g) A detailed list of all Managed Care providers;
- (h) By health plan of open prior authorizations for recipients newly enrolled to managed care;
- (i) Managed care enrollment statistics;
- (j) Encounter data 997 and remittance advices provided to managed care providers;
- (k) Monthly reconciliation data reports/files for managed care providers;
- (l) Managed care rosters for all health plans that contain related recipient data in the recipient data maintenance function including an indicator for recipients certified as members of recognized Indian tribes; all TPL information; and recipient profile information including, language spoken, handicap access needed, health status identifying specialized medical needs (including any open prior authorizations, and recipient risk assessment data); and
- (m) Notices/letters to recipients.

17. Delete Section C.6.3.1 in its entirety and substitute the following:

C.6.3.1 Inputs

The inputs to the Reference Data Maintenance function are:

- 1. District-approved updates for procedure, drug, diagnosis, edit/audit criteria, and edit disposition files;
- 2. Bi-weekly updates from a contracted drug pricing service for drug codes and prices;
- 3. CMS - HCPCS updates;
- 4. Revenue code updates; and
- 5. ICD-9 diagnosis and procedure updates.

18. Delete Section C.6.3.4 in its entirety and substitute the following:

C.6.3.4 Interfaces

The Reference Data Maintenance function must interface with:

- 1. Drug updating service,
- 2. CMS-HCPCS updates,
- 3. ICD-9 or other diagnosis/surgery code updating service,

4. DRG Updates,
5. Revenue code updates, POS Contractor, and
6. Data Warehouse and Web Portal.

19. Delete Section C.6.8 in its entirety and substitute the following:

C.6.8 CLAIMS AND ENCOUNTER PRICING

The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each claim type, category of service, and type of provider. This process takes into consideration the Medicaid allowed amount, TPL payments, Medicare payments, patient payments and prior authorized amounts. Prices are maintained on the Reference files or provider-specific rate files and are date-specific.

The MMIS shall process and pay Medicare crossover claims.

20. Delete Section C.6.8.1 in its entirety and substitute the following:

C.6.8.1 Inputs

The inputs into the Claims Pricing function are the claims and encounters that have been passed from the editing cycles for pricing

The Reference, Provider, and PA files containing pricing information are also inputs to this function.

21. Delete Section C.6.8.2 through C.6.8.2.11 in their entirety and substitute the following:

C.6.8.2 Processing Requirements

The Claims and Encounter Pricing function of the MMIS shall have the capabilities to:

- C.6.8.2.1 Identify the price for claims according to the date-specific pricing data and reimbursement methodologies contained on Provider or Reference files based on date of service on the claim.
- C.6.8.2.2 Edit billed charges for high and low variances and flag any exceptions.
- C.6.8.2.3 Identify and calculate payment amounts according to the fee schedules, per diem, rates, and rules established by the District including the possible expanded use of fee schedules for outpatient services besides outpatient laboratory services.
- C.6.8.2.4 Maintain access to pricing and reimbursement methodologies to appropriately price claims based on:
1. Fee schedules for physicians, dentists, and other practitioners;
 2. DRGs, per diem, and percent of charges for inpatient hospital services;
 3. Fee schedules for laboratory outpatient services and other pricing methods for outpatient services;
 4. Per diem for nursing homes;
 5. Medicare deductible and coinsurance amount for crossover claims; and
 6. Per capita monthly amount for HMOs.
- C.6.8.2.5 Deduct patient liability amounts when pricing long-term care claims.
- C.6.8.2.6 Deduct TPL amounts, as appropriate, when pricing claims.
- C.6.8.2.7 Bypass TPL logic for encounters and store HMO paid amounts that are passed in the COB loop of the 837 HIPAA format;
- C.6.8.2.8 Provide for the ability to price Medicare coinsurance or deductible crossover claims either at the Medicaid allowed amount or as the amount of coinsurance and deductible. In pricing by Medicaid allowed amount, Part B Medicare pricing should be done at the line item level.
- C.6.8.2.9 Ensure that the Medicare crossover claims for which, payments is requested, are covered by the District of Columbia Medical assistance program and that the Medicare portion of the claim had already been **paid.**

- C.6.8.2.10 Maintain flexibility to accommodate pricing of alternative service delivery systems, such as case-management, managed care, and HMOs without major system modifications, including alternative pricing for case managers or gatekeepers.
- C.6.8.2.11 Price procedure codes allowing for multiple modifiers, which enable reimbursement at varying percentages of allowable amounts.
- C.6.8.2.12 Maintain multiple prices (at least 36 prices) for each LTC provider reimbursement methodology.
- C.6.8.2.13 Provide processes and dates to meet the minimum requirements of Part 11 of the State Medicaid Manual.

22. Delete Section C.6.10.1 and C.6.10.1 in their entirety and substitute the following:

C.6.10 CLAIMS AND ENCOUNTER OPERATIONS MANAGEMENT

The Claims Operations Management function provides the overall support and reporting for all of the claims processing functions. It specifies the on-line claims status and history, processing cycles, and inventory and other general reporting requirements for the claims processing functions.

C.6.10.1 Inputs

The inputs to the Claims and Encounter Operations Management function shall include all the claim and encounter records from each processing cycle and other inputs described in Subsection C.6.6.1.

23. Insert section C.6.10.3.17 in its entirety and substitute the following:

- C.6.10.3.17 Detailed and summary encounter reports by submission and monthly financial reconciliation reports.

24. Delete Section C.8.16.6.6 sub-paragraph (d) in its entirety and substitute the following:

- (d) Claims and encounter processing status

25. Delete Section H.24.1 in its entirety and substitute the following:

H.24.1 Clean Claims - is a claim or encounter that is denied or paid in its initial adjudication cycle without human intervention.

26. Delete Section H.35.1 in its entirety and substitute the following:

H.35.1 CONDITIONS ON APPROVAL OF CERTIFIED MMIS SYSTEM

The Contractor shall propose a fully certified or certifiable MMIS system as described in Section C.1 that satisfies all conditions classified by CMS certification guidelines which shall include the CMS certification approval letter. The Contractor shall satisfy all such conditions as a prerequisite to the satisfactory conclusion of the District of Columbia MMIS Enhancement and Implementation Task, Acceptance Test Subtask milestones. These conditions cannot be passed on to the District of Columbia MMIS in whole or in part.